South Carolina Department of Health and Human Services

Emergency Certification for Medicaid in South Carolina

SECTION I

TO: SSA District or Branch Manager SUBJECT: Emergency Certification for Medicaid in South Carolina	From: Date:

Please check the entitlement for an SSI and/or Mandatory Supplementation payment for the individual listed below. Please complete Section II of this form if the individual has current entitlement or had past entitlement but has not appeared on the SDX. Send the completed form to:

South Carolina Department of Health and Human Services
Division of MEDS User Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Individual's Name: (Last, First, MI)	Social Security Number:	HIB Claim Number (if available to DHHS):
Medicaid Number (if available):	Received in South Carolina Previously: (indiv.)	

SSA Local Office Where Claim Was Originally Filed (Applicable Only for Newly Eligible SSI Recipients):

Street Address: _____City: _____

Remarks: _____

_____

_____

Emergency Certification for Medicaid in South Carolina (continued)

SECTION II

A.

SSN INDIVIDUAL	TRANS. CODE	MSTR FILE CODE	CURRENT SSI ENTITLEMENT DATE	MOST RECENT SSI ENTITLEMENT DATE	BIRTHDATE	SEX	RACE
£ £ £ £ £ £ £ £ £	£ £	£ £	£ £ £ £ £ £	£ £ £ £ £ £	£ £ £ £ £ £	£	£

SSI AMOUNT	SSA CLAIM NUMBER	MEDICARE STATUS
£ £ £ £ £ £	£ £ £ £ £ £ £ £ £ £ £ £	£

MEDICARE STATUS CODES

A-PART A ONLY C-BOTH
B-PART B ONLY D-NONE

B.

INDIVIDUAL'S LAST NAME	FIRST	MI	LIVING ARRANGEMENT	COUNTY CODE RESIDENCE
£ £ £ £ £ £ £ £ £ £ £ £ £ £ £ £ £ £	£ £ £ £ £ £ £ £ £ £	£	£	£ £ £

PAYEE TYPE	PAYEE'S LAST NAME	FIRST	MI
£ £ £	£ £ £ £ £ £ £ £ £ £ £ £ £ £ £ £ £ £ £	£ £ £ £ £ £ £ £ £ £	£

MAILING ADDRESS: _____

ZIP CODE

_____ £ £ £ £ £

RESIDENCE ADDRESS: _____ DATE OF INPUT

(If different from mailing address) ZIP CODE TO SSR

_____ £ £ £ £ £ £ £ £ £ £ £

SECTION III	REMARKS
CLOSED EFFECTIVE DATE £ £ £ £ £ £ DEATH DATE £ £ £ £ £ £	
SECTION IV	
I certify that the above-named individual or eligible spouse is currently entitled or had past entitlement to a Supplemental Security Income payment and/or Mandatory Supplementation payment.	
District or Branch Number: / Date:	
Signature of Individual Completing Form for SSA:	

DHHS Form 1251ME (Sept 2003)